REGISTRATION

Patient Information

Patient's Name _____SSN _____ Date of Birth _____ Male ☐ Female ☐

How do you wish to be addressed _____ Single ☐ Married ☐ Separated ☐ Widowed ☐

Minor ☐

Address _____ City _____ State _____ Zip _____

Home Phone _____ Office Phone _____Ext_____ Cell Phone_____

Email _____Who may we thank for referring you? _____

Someone to notify in case of emergency _____ Phone_____

Other family members in this practice _____

Account Information

Responsible Party's Name _____ Date of Birth _____ Male ☐ Female ☐

SSN_____ Driver's License # _____ State _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Office Phone _____Ext_____ Cell Phone_____

Primary Dental Insurance

Insured's Name _____Date of Birth _____

Employed By _____Occupation_____

Relationship to the patient: Self ☐ Spouse ☐ Parent ☐

Name of Insurance Co. _____ Phone _____

Address _____ City _____ State _____ Zip _____

Policy/Group # _____Insured's ID _____ Insured's Social Security # _____

Secondary Dental Insurance

Insured's Name _____Date of Birth _____

Employed By _____Occupation_____

Relationship to the patient: Self ☐ Spouse ☐ Parent ☐

Name of Insurance Co. _____ Phone _____

Address _____ City _____ State _____ Zip _____

Policy/Group # _____Insured's ID _____ Insured's Social Security # _____

Release

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.
I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
I attest to the accuracy of the information on this page.

Patient's or Guardian's Signature _____ Date _____